CLOVIS ADULT EDUCATION

IMPROVING LIVES THROUGH EDUCATION

CLOVIS UNIFIED SCHOOL DISTRICT

Health Requirements

IMPORTANT NOTE:

This form is to be reviewed by the Physician filling out the Physical Examination Form.

To enter into and complete any **Nursing and Allied Health Program** at Clovis Adult, students must be able to meet the following requirements:

Mental/Emotional

Students must have sufficient emotional stability to perform under stress produced by academic study and the necessity of performing patient care in real patient care situations while being observed by instructors and agency personnel.

Strength and Stamina

Students must be able to:

- ☐ Work at various clinical sites up to 8-12 hours per day.
- ☐ Attend theory classes up to 8 hours per day.
- ☐ Lift /transfer patients of various sizes and weights on to & off of examination tables.
- ☐ Push, pull, lift, turn as in patient positioning, and manipulating equipment.
- ☐ Lift up to 50 pounds, floor to waist and waist to shoulder.
- ☐ Power grasp (as in examination table and injection control)
- ☐ Walk up to 500 feet.
- ☐ Sit for prolonged periods.
- ☐ Stand for prolonged periods.

Flexibility

Students must be able to:

- ☐ Reach above shoulder height
- ☐ Bend over
- ☐ Crouch to stoop
- ☐ Twist

Fine manipulation

Students must be able to:

- ☐ Manipulate ampoules, syringes, and medication containers.
- ☐ Write legibly and enter data into computers using touch screens and keyboards.

Sensory abilities

Students must be able to:

- ☐ See well enough to read syringe graduations and medication labels.
- ☐ Hear well enough to receive information accurately over the telephone and to discriminate sounds heard through a stethoscope.
- ☐ Use all physical senses (hearing, seeing, feeling, and smelling) in a manner that allows the student to accurately assess the patient and clinical situation.

Pregnancy

Students must be able to:

- ☐ Provide a release from their OB doctor to be in the clinical setting with no restrictions.
- ☐ Have a ***monthly*** documented release that the student may *continue* in clinical with no restrictions

In addition to the above mentioned requirements, students must have adequate management of chronic illnesses so that neither patients nor the student is at risk of harm.

Students must complete all required immunizations and the health screening to participate in the Nursing Program.

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NURSING and ALLIED HEALTH EDUCATION
STUDENT HEALTH QUESTIONNAIRE

Date: _____ Program: _____

Name: _____ (First) _____ (Last) _____ (MI) DOB: _____ Sex: ○ M ○ F

Address _____ (Street) _____ (Apt #) _____ (City) _____ (State) _____ (Zip)

Phone #: _____ Alternate # _____

Family Physician: _____ Phone _____

Under current medical care? ○ Yes ○ No If yes, please explain: _____

Family History: Nervous or Mental Illness? ○ Yes ○ No Diabetes? ○ Yes ○ No Tuberculosis? ○ Yes ○ No

Have you had or do you have any problems with the following: (Please answer to the best of your knowledge)

DISEASE OF:	YES	NO	DISEASE OF:	YES	NO	DISEASE OF:	YES	NO
Brain	☐	☐	Genitals	☐	☐	Bronchitis	☐	☐
Rheumatic Fever	☐	☐	Eyes	☐	☐	Lymph	☐	☐
Paralysis	☐	☐	Ears	☐	☐	Chronic constipation	☐	☐
Frequent or painful urination	☐	☐	Nose	☐	☐	Black or bloody bowel movements	☐	☐
Frequent sore throat	☐	☐	Cancers/Tumors	☐	☐	Frequent headaches	☐	☐
Hay Fever	☐	☐	Heart	☐	☐	Asthma	☐	☐
Swollen ankles	☐	☐	Lungs	☐	☐	Blood in urine	☐	☐
Fainting Spells	☐	☐	Diabetes	☐	☐	Stomach	☐	☐
Intestine	☐	☐	Arthritis	☐	☐	High blood pressure	☐	☐
Hernia (rupture)	☐	☐	Chest pains	☐	☐	Jaundice	☐	☐
Chronic cough	☐	☐	Liver	☐	☐	Shortness of breath	☐	☐
Coughing up blood	☐	☐	Spleen	☐	☐	Nervous breakdown	☐	☐
Backaches	☐	☐	Ulcers	☐	☐	Painful flat feet	☐	☐
Kidney stones	☐	☐	Gallbladder	☐	☐	Pneumonia	☐	☐
Bone	☐	☐	Kidneys	☐	☐	Chronic sinus infections	☐	☐
Chronic indigestion	☐	☐	Bladder	☐	☐	Allergies	☐	☐
Tuberculosis	☐	☐	Injuries	☐	☐	Operations	☐	☐
Vomiting of blood	☐	☐	Piles	☐	☐	Convulsions or seizures	☐	☐
Abnormal menstrual periods	☐	☐	Joints	☐	☐	Recurrent nausea	☐	☐
Bleeding disorder	☐	☐	Back (spine)	☐	☐	Recurrent vomiting	☐	☐

Please give details of information to all "yes" answers on the reverse of this page 

Any other serious illnesses (Please explain) _____

- Do you hear well? ○ Yes ○ No If NO explain: _____
- Do you see well? ○ Yes ○ No If NO, explain: _____
- Have you ever been rejected or discharged from the military service because of illness or injury? ○ Yes ○ No
- If YES, explain: _____
- Do you have any defect, deformity or disease, which may interfere with your work? ○ Yes ○ No

  If YES, please state details of illnesses, injuries, operations or defects _____

I, the undersigned, certify the above answers are true, and give the examining Physician permission to submit a report to the Clovis Adult Education Nursing and Allied Health Department.

Student Signature _____ Date _____

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NURSING and ALLIED HEALTH EDUCATION

Physical Examination Form

Program: _____

NAME: _____ Date of Birth _____

HEIGHT: _____ ft _____ in WEIGHT: _____ lbs B/P:_____ TEMP: _____ RESP _____

HEENT: _____

CARDIOVASCULAR: _____

GI: _____

EXTREMETIES: _____

NEUROLOGICAL: Able to perform fine motor skills? ○ Yes ○ No

MUSCULO/SKELETAL: Able to assist to lift patients of varying weights and sizes? ○ Yes ○ No

IMPORTANT: The following questions MUST be answered by the Physician

This person is free of communicable disease and does not have any health condition(s) that would create a hazard to himself, fellow students, residents, patients or visitors. ○ YES ○ NO

If no, please Explain:_____

Attached is a list of "Health Requirements"

Does this person have the ability to meet these health requirements? ○ YES ○ NO

If no, please Explain_____

Dr. Signature: _____ Date: _____

Address: _____ Phone: _____

**Please attach doctor's office business card to this form and/or doctor's office stamp here.

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NURSING and ALLIED HEALTH EDUCATION

Immunization Requirements

Program _____

Name_____ Date of Birth _____

IMPORTANT: *Documentation such as a printout or a written prescription stating that the following has been completed, MUST be attached to this form.*

QuantiFERON Gold Test (Now required for VN & CNAP Students) Date given _____ Result _____

PPD (TB) Date given _____ Date read _____ Result _____ Given by _____

PPD (TB) Date given _____ Date read _____ Result _____ Given by _____

Chest X-ray Date given _____

Influenza (Flu) Vaccine: Date given _____ Given by_____

Tdap (Pertussis) Vaccine Date given _____

Rubella Positive titer date _____ or 2 immunizations #1 date _____ #2 date_____

Rubeola Positive titer date _____ or 2 immunizations #1 date _____ #2 _____

Mumps Positive titer date _____ or 2 immunizations #1 date _____ #2 date_____

Varicella Positive titer date _____ or 2 immunizations #1 date _____ #2 _____

Hepatitis B Positive titer date _____ or series of 3 immunizations

Hepatitis #1 _____ Hepatitis #2_____ Hepatitis 3_____

Additional Notes: _____

Dr. Signature: _____ Date: _____

Address: _____ Phone: _____

City, State, Zip: _____

**Please attach doctor's office business card to this form and/or doctor's office stamp here.